DPHHS-SLTC-220
(New 7/14)

STATE OF MONTANA
Department of Public Health and Human Services

Agency Based-CFC/ABPAS SERVICES DELIVERY RECORD

Employee Name	**Consumer Name**	**Medicaid ID (optional)**	**Pay Period (Mo/Day/Yr)- Mo/Day/Yr)**

		Su	**M**	**T**	**W**	**Th**	**F**	**S**	**Su**	**M**	**T**	**W**	**Th**	**F**	**S**
Employees must complete all sections of the service delivery record in order to obtain payment.	**Date**														
	Time In														
	Time Out														
	Total (a+b+c)														
ACTIVITIES OF DAILY LIVING (ADL)															
Bathing															
Personal Hygiene															
Meal Preparation & Eating															
Exercise															
Medication Reminder															
Other: *(approved by MPQH)*															
Other: *(approved by MPQH)*															
Other: *(approved by MPQH)*															
INSTRUMENTAL ACTIVITIES OF DAILY LIVING															
Household Maintenance (HM)															
Correspondence Assistance (CA) - CFC Only															
a) ADL, Household, Correspondence Total															
b) Community Integration (CI) /Shopping -- Daily Time															
c) Skill Acquisition –CFC only-Time															

A. ADL,HM and CA Total Time:___ B. CI and Shopping Total Time: ____ C. Skill Acquisition Total Time: _____ Total AB Time:____

All services under HCBS/Medicaid Waiver must be <u>pre-approved</u> by the case management team.	**Date**														
	Time In														
	Time Out														
	Total														
Social Supervision															
Homemaking															

Comments:

This is to certify that I worked the hours recorded and completed the work tasks assigned.

This is to certify that to the employee has worked the hours recorded, completed the tasks assigned.
Misrepresentation constitutes fraud

Consumer Signature **Date**

Employee Signature **Date**

Agency Representative Signature **Date**